Wisconsin HEALTH INFORMATION Organization

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Wisconsin Collaborative for Healthcare Quality

Wisconsin Medical Society

Dept. of Health Services

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Wisconsin Hospital Association

March 3, 2010 Assembly Bill 779

Good Morning Mr Chairman and members of the committee.

My name is Jo Musser and I am here today representing the members of the Wisconsin Health Information Organization or WHIO to speak in support of the Bill.

Some of you may be aware that I have been working in the field of health care for nearly 35 years and most of that time focused on ways to improve quality and safety and reduce costs.

The members of WHIO are a very diverse group of stakeholders in the Health Care Industry who have come together to find opportunities to improve the quality and affordability of health care in Wisconsin through the collection and dissemination of actionable data that reflects the performance-- through both quality and efficiency measures-- of each physician and hospital in our State.

WHIO is unusual in that it is a public private voluntary non-profit organization. Many initiatives have been undertaken in other states to accomplish what WHIO has accomplished, but none have been as successful in actually producing robust data and powerful analytics and making them available to providers.
The interests of WHIO are aligned with funding HIE in WI.

Facilitating the capabilities offered through electronic health information exchange can greatly contribute to improving quality, safety and affordability of care.

Let me provide one example. I recently did an analysis of the costs of providing laboratory and radiology services to an insured population of 120k members for one year. The total charges paid to doctors and facilities for these services for this population for one year were $89M.

Now, many in health care would agree that at least 10% of those tests were done because the information from a previously performed test was not available to the doctor when he or she needed it to support clinical decision-making.

That means that $8.9M dollars of unnecessary lab and xray services were billed.

The capability offered through HIE would make information on tests results, allergies, medications and the presence of additional disorders (co-morbidities) available to the physician to support clinical decision in a timely and accurate fashion. Stating the obvious—this improves the safety, quality and efficiency of health care to the patient.

Annually, nearly 100k deaths occur due to medical errors. The availability of timely and credible information could greatly impact and reduce that number.

WHIO has been successful because of the commitment of leaders, many of whom have very different and often competitive agendas. But we worked long and hard through the difficulties of establishing trusting relationships and balancing power.

We work very closely with the medical society to deliver performance reports to physicians.

We work very closely with the hospital association to educate their members on the availability of our powerful tools to help them improve care.

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We work closely with the Collaborative (I am a member of that Board as well) to validate data and educate physicians on their performance measures.

Others who have tried to establish initiatives like WHIO in their states look at us and wonder how we were able to stick it out through obvious competing interests among physicians, hospitals, employer groups, insurers, state government and even competing membership organizations. The answer is that the members of the group are committed to contributing to the solutions in health care in spite of their differences. It took a long time and a lot of work to build this team. But it is an excellent example of what can be accomplished in a private-public partnership.

And our team is ready to support the HIE initiative in Wisconsin in any way that we can be of assistance.

Thank you for allowing me to present our views and I am happy to answer additional questions if there are any.

Wisconsin HEALTH INFORMATION Organization

Affiliation Group Profile
Presented by WHIO

Specialty Patterns of Care

[illegible]

Affiliation Group

Affiliation ID:	123456
Affiliation Description:	Buck E. Badger Medical Group-Algoma INTERNAL MEDICINE
Number of Providers:	12
Number of Episodes:	2,984
Case Mix Episodes:	0.73

Peer Group

Peer Group Number of Episode	184,724
Peer Group Name:	WHIO PCP (Internal Medicine)

Key Statistics

Overall Quality Index:	0.90
Overall Cost Index, Episode:	1.08

Confidence Intervals for the Index

Overall Quality Index:	0.89 to 0.91 **
Overall Cost Index, Episode:	1.04 to 1.11 **

Statistical significance of difference between index and peer group average: * p<0.10; ** p < 0.05

Episode Case Mix Summary

Top 10 ETGs, by Total Cost (Completed Episodes of Care)

ETG Family Description	Episodes			Encounters (Per 1000 Episodes)	
	Episodes	Actual Cost / Episode	Peers Cost / Episode	Actual Encounters / 1000 Episodes	Peers Encounters / 1000 Episodes
Hypertension	533	$886.28	$714.15	11,590	11,703
Diabetes	181	$1,677.31	$1,626.87	16,277	18,158
Hyperlipidemia, other	287	$483.57	$503.00	5,491	6,076
Joint degeneration, localized	65	$1,244.96	$1,005.46	7,556	7,463
Hypo-functioning thyroid gland	119	$653.89	$524.81	11,677	11,202
Asthma	92	$631.14	$891.96	6,868	8,353
Ischemic heart disease	25	$2,246.29	$2,499.78	12,430	16,207
Adult rheumatoid arthritis	4	$10,370.12	$3,529.38	16,313	16,632
Obesity	91	$431.64	$390.02	4,344	3,935
Acute bronchitis	219	$176.35	$173.50	3,102	3,149
All Others	1,367	$354.44	$359.94	3,618	3,854
All Episodes	**2,984**	**$600.63**	**$560.36**	**6,573**	**6,920**

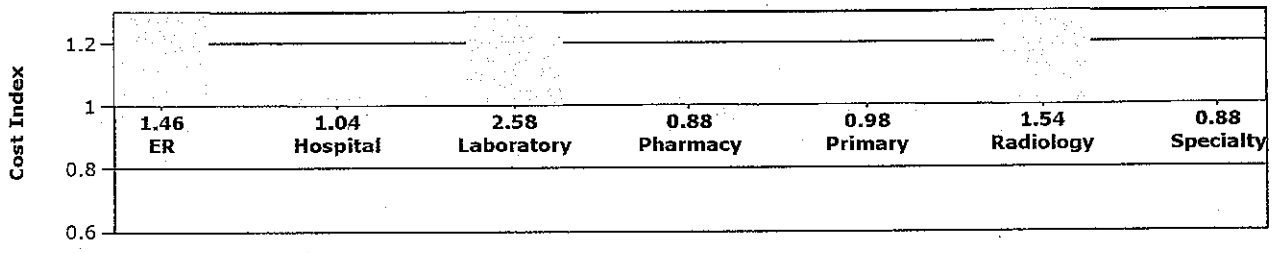
Quality Measures

As of the End of the Report Period
(Members Must be Continuously Enrolled with Plan a Minimum of 12 Months)

	Number of Quality Opportunities		Rates		Index
	With Compliance	Total	Actual Rate	Peer Rate	Quality Index
Cardiology					
CAD (NS)					
Pt(s) presc lipid-lowering therapy during the msrmt year.	7	12	0.58	0.65	0.90
CAD (NS)					
Pt(s) w/ CAD and diabetes and/or CHF presc ACE-inhibitor or angiotensin II receptor antagonist therapy during the msrmt year.	3	4	0.75	0.76	0.98
CAD (NS)					
Pt(s) with a lipid profile (or ALL component tests) during the measurement year.	6	12	0.50	0.84	0.59
CHF (NS)					
Pt(s) presc ACE-inhibitor or angiotensin II receptor antagonist therapy during the msrmt year.	0	1	0.00	0.68	0.00
CHF (NS)					
Pt(s) presc beta-blocker therapy during the msrmt year.	0	1	0.00	0.34	0.00
Endocrinology					
Diabetes					
Pt(s) that had at least 2 HbA1c tests in last 12 reported mos.	59	89	0.66	0.76	0.87
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age that had an annual screening test for diabetic retinopathy.	55	162	0.34	0.44	0.77
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age that had annual screening for nephropathy or evidence of nephropathy.	99	162	0.61	0.79	0.77
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age with a LDL cholesterol in last 12 mos.	88	162	0.54	0.82	0.66
Orthopedics and Rheumatology					
LBP Imaging (NS)					
Pt(s) w/ uncomplicated low back pain that did not have imaging studies.	30	52	0.58	0.72	0.80
Otolaryngology					
Pharyngitis (NS)					
Pt(s) treated w/ an abx for pharyngitis that had a Group A streptococcus test.	1	1	1.00	0.82	1.21
Preventive and Administrative					
Breast CA Scrn (NS)					
Pt(s) 42 - 69 yrs of age that had a screening mammogram in last 24 rpt mos.	368	485	0.76	0.83	0.92
Chlamydia Scrn (NS)					
Pt(s) 16 - 25 yrs of age that had a chlamydia screening test in last 12 rpt mos.	19	55	0.35	0.36	0.95
Psychiatry					
Depression Med Mgmt (NS)					
Pt(s) w/ a new episode of depression that had 3 or more prov contacts during the 3 mos after initial dx, where at least 2 were face -to-face, and at least one was w/ a presc prov.	0	4	0.00	0.14	0.00
Depression Med Mgmt (NS)					

Pt(s) w/ a new episode of depression that remained on an antidepressant med during the 12 week acute tx phase.	4	4	1.00	0.73	1.37
Depression Med Mgmt (NS)					
Pt(s) w/ a new episode of depression that remained on an antidepressant med during the 6 month acute tx phase.	1	4	0.25	0.49	0.51
Pulmonology					
Asthma (NS)					
Pt(s) w/ presumed persistent asthma using an inhaled corticosteroid or acceptable alternative.	15	15	1.00	0.94	1.07
Bronchitis, Acute (NS)					
Pt(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	13	113	0.12	0.21	0.55
COPD Exacerbation (NS)					
Pt(s) 40 years of age and older with COPD exacerbation that received a bronchodilator within 30 days of the hospital or ED discharge.	1	1	1.00	0.82	1.21
COPD Exacerbation (NS)					
Pt(s) 40 years of age and older with COPD exacerbation that received a systemic corticosteroid within 14 days of the hospital or ED discharge.	0	1	0.00	0.58	0.00
URI (NS)					
Pt(s) w/ a dx of URI that did not have a presc for an abx on or 3 dys after the initiating visit.	1	1	1.00	0.84	1.19
Total	**770**	**1,341**	**0.57**	**0.69**	**0.83**

Cost Index Summary by Service Category



Cost and Utilization Summary Measures

Profiled Costs

	Actual Encounters	Peers Encounters	Actual Cost / Episode	Peers Cost / Episode	Cost / Episode Index	Actual Total Cost
ER	**91**	**83**	**$18.14**	**$12.42**	**1.46**	**$54,125.61**
Hospital Services	**1,776**	**629**	**$81.40**	**$78.29**	**1.04**	**$242,860.84**
Laboratory	**1,689**	**1,053**	**$74.73**	**$28.96**	**2.58**	**$222,951.46**
Pharmacy	**9,762**	**10,602**	**$181.61**	**$205.59**	**0.88**	**$541,840.57**
Primary Care Core	**4,268**	**4,773**	**$111.01**	**$113.71**	**0.98**	**$331,201.34**
Radiology	**348**	**277**	**$63.65**	**$41.37**	**1.54**	**$189,904.39**
Specialty Care	**1,678**	**3,228**	**$70.08**	**$80.02**	**0.88**	**$209,092.58**
Total	**19,611**	**20,645**	**$600.63**	**$560.36**	**1.07**	**$1,791,976.79**

Overall Cost Index: 1.08

Utilization Rates Per 1,000 Episodes

	Actual	Peers	Index
Specialist Visit Rate	1,276	1,278	1.00
Other Specialty Care Rate	241	229	1.05
Radiology Procedure Rate	167	148	1.12
MRI Procedure Rate	12	9	1.41
Laboratory Procedure Rate	695	634	1.10
Overall Prescribing Rate	3,272	3,554	0.92
Generic Prescribing %	92%	91%	1.01
ER Visit Rate	27	26	1.06
Admits per 1000 Episodes	5	8	0.58
Days per 1000 Episodes	15	51	0.29
Average Length of Stay	3.14	6.22	0.50

Episode Detail and Analysis

Hypo-functioning thyroid gland

Total Specialty Episode Costs: $77,758

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	119	$653.89	$154.59	$36.83	$217.95	$28.44	$43.92	$160.98	$11.17
Peers		$524.81	$127.96	$39.49	$101.28	$17.37	$26.32	$208.14	$4.25
Index			1.21	0.93	2.15	1.64	1.67	0.77	2.63
Encounters per 1000 Episodes									
Actual			1,643	420	1,568	54	1,290	6,685	17
Peers			1,532	1,363	1,171	31	234	6,863	8
Index			1.07	0.31	1.34	1.71	5.50	0.97	2.15

Diabetes

Total Specialty Episode Costs: $304,012

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	181	$1,677.31	$212.62	$179.20	$159.98	$63.64	$144.10	$826.40	$91.35
Peers		$1,626.87	$233.75	$249.07	$61.99	$43.04	$144.90	$855.60	$38.53
Index			0.91	0.72	2.58	1.48	0.99	0.97	2.37
Encounters per 1000 Episodes									
Actual			2,321	1,204	1,095	79	1,556	9,870	152
Peers			3,217	3,249	818	53	446	10,305	69
Index			0.72	0.37	1.34	1.51	3.48	0.96	2.20

Hyperlipidemia, other

Total Specialty Episode Costs: $138,905

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	287	$483.57	$89.19	$7.74	$112.24	$9.91	$23.85	$239.03	$1.61
Peers		$503.00	$72.57	$10.57	$37.75	$7.93	$5.54	$367.99	$0.65
Index			1.23	0.73	2.97	1.25	4.30	0.65	2.49
Encounters per 1000 Episodes									
Actual			924	167	853	23	759	2,764	2
Peers			930	672	495	8	77	3,893	1
Index			0.99	0.25	1.72	2.87	9.79	0.71	1.41

Hypertension

Total Specialty Episode Costs: $472,163

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	533	$886.28	$164.98	$68.56	$140.61	$81.73	$141.28	$257.76	$31.37
Peers		$714.15	$172.72	$86.15	$40.27	$60.69	$86.61	$251.77	$15.93
Index			0.96	0.80	3.49	1.35	1.63	1.02	1.97
Encounters per 1000 Episodes									
Actual			2,075	627	1,009	133	1,021	6,675	50
Peers			2,349	1,348	384	98	327	7,166	31

Index	0.88	0.47	2.62	1.35	3.13	0.93	1.63

Chronic sinusitis

Total Specialty Episode Costs: $30,801

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	95	$325.08	$111.87	$27.76	$2.65	$50.23	$3.37	$129.21	$0.00
Peers		$385.83	$106.57	$46.46	$5.51	$52.74	$10.47	$156.33	$7.76
Index			1.05	0.60	0.48	0.95	0.32	0.83	0.00
Encounters per 1000 Episodes									
Actual			1,652	380	47	71	84	2,290	0
Peers			1,564	596	62	95	86	2,664	22
Index			1.06	0.64	0.77	0.75	0.98	0.86	0.00

Acute bronchitis

Total Specialty Episode Costs: $38,621

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	219	$176.35	$85.88	$9.23	$3.14	$8.99	$7.24	$58.68	$3.19
Peers		$173.50	$88.11	$12.13	$2.53	$6.24	$6.74	$52.45	$5.31
Index			0.97	0.76	1.24	1.44	1.07	1.12	0.60
Encounters per 1000 Episodes									
Actual			1,254	176	33	46	96	1,484	14
Peers			1,360	262	33	38	72	1,365	19
Index			0.92	0.67	1.02	1.21	1.34	1.09	0.71

Asthma

Total Specialty Episode Costs: $58,065

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	92	$631.14	$128.65	$50.39	$19.94	$18.01	$63.01	$325.20	$25.94
Peers		$891.96	$138.12	$135.89	$17.48	$25.09	$124.75	$421.78	$28.85
Index			0.93	0.37	1.14	0.72	0.51	0.77	0.90
Encounters per 1000 Episodes									
Actual			1,578	755	108	103	487	3,804	33
Peers			1,835	1,311	103	89	380	4,578	57
Index			0.86	0.58	1.05	1.16	1.28	0.83	0.57

Joint degeneration, localized

Total Specialty Episode Costs: $81,130

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	65	$1,244.96	$106.18	$237.82	$18.95	$520.45	$272.07	$52.63	$36.87
Peers		$1,005.46	$104.98	$234.42	$9.94	$316.02	$192.01	$138.71	$9.39
Index			1.01	1.01	1.91	1.65	1.42	0.38	3.93
Encounters per 1000 Episodes									
Actual			1,420	1,987	150	850	1,176	1,918	54
Peers			1,398	2,465	97	708	563	2,210	23
Index			1.02	0.81	1.55	1.20	2.09	0.87	2.34

Report Introduction and Interpretation

Patterns of Care

This section gives an overview of the performance of the report entity for the 12 month period ending on the date in the banner of the section. Note that claims paid in the 3 months after that date for dates of service in those 12 months prior to the date are included in the data. All comparisons in the report are with the report entity peer group, based on a peer definition centered on a specialty. The peer group defines how and what episodes and quality measures are attributed, as well as how those episodes are attributed. For example, a specific subset of ETGs and quality measures are assigned to the peer group General Surgery. The Peer Group Name identifies the comparison group for the report. Note that the episode information on which all of this report is based is for completed, non-outlier episodes that ended during the last 12 months of the report period. Episodes may be attributed to only one provider in a peer group, but may be attributed to more than one peer group.
Number of Providers: This field, in a group report only, reports the number of providers in this peer group with the same affiliation ID, who had episodes attributed during the 12 month reporting period.
Number of Episodes: The total number of complete, non-outlier, within the peer group definition episodes attributed to the providers included in the report during the 12 month reporting period
Case Mix Episodes: This ratio expresses the relative health risk represented by the report entity's attributed episodes compared to that represented by the attributed episodes for the peer group. Episode Risk Groups (ERGs) are used for the calculation. Thus, a value equal to 1 would indicate that the disease burden for the episodes attributed in this report is exactly the same as the disease burden for all of the episodes captured by all members of the peer group.
Overall Quality Index: This ratio represents the relative performance of the report entity on the set of evidence-based medicine measures included in the peer group definition compared to the performance of the peer group as a whole. The set of rules included for primary care is quite large, approximately 250 rules, spanning a number of disease entities. The higher the index , the better the performance of the report entity relative to the peer group on these measures. This ratio will usually be different from the Quality Index in the Quality Measures section of the report as that index only represents the relative performance for the subset of measures included in that section of the report.
Overall Cost Index, Episode: This ratio represents the costs for the episodes attributed to the report entity relative to the average costs for the peer group for the exact same set of episodes, with the comparisons made at the episode severity level. The lower the number, the lower the costs are for the report entity relative to the peer group for the set of episodes. Note that all claims are standard priced, eliminating contractual payment differences as drivers of cost differences throughout the report. Cost differences are driven by units of service and mix of services for an episode of care. The overall cost index is adjusted across the peer group by weighting at the service category level to account for differences in estimated impact of control by a peer group specialty (see Cost Index Summary, by Service Category section of the report explanation).
Confidence Intervals: Each index has a range that reflects the 90% confidence interval around the index value. The confidence intervals are used to indicate the reliability of the value. A 90% confidence interval represents the 90% statistical probability that the value actual value lies within that interval. As a general rule, the more episodes or EBM measures the narrower the confidence interval.
The asterisks associated with the confidence intervals represent the statistical significance of the difference between the index and the peer group average, expressed as a p value. This is attempting to answer the question, "is this entity's performance truly statistically different from peers?" The peer group index is 1.0. One asterisk, representing $p< 0.10$, would indicate that the answer to that question is yes, as the 90 % confidence interval does not include 1.0. Two asterisks, representing $p< 0.05$, would indicate that the answer to that question is a statistically stronger yes, as the 95% confidence interval does not include 1.0.

Episode Case Mix Summary

This section of the report is a tabular summary of the top 10 episode families by total cost (number of episodes times average standard cost per episode for the report entity). This provides an overview of those episodes that contribute the most to costs of care for the report entity. Note that the term actual throughout the report should be interpreted as the standard priced result for the report entity for cost measures and the actual encounters for the report entity for encounter measures. These results will be compared to the standard priced results and encounter results for the peer group for the exact same set of episodes, with the comparisons made at the episode severity level.

Quality

WHIO, in conjunction with its Clinical Advisory Panel, has chosen a subset of the evidence-based medicine quality measures to be displayed in this section of the report. The measures in this report are only for rules associated with the episodes attributed to the report entity. Thus, if an internist affiliated with the entity in the report cares for a diabetic, but the diabetic's episode of care is attributed to an endocrinologist and does not meet the threshold (thirty percent of services) for attribution to the internist, the EBM measures for which that diabetic met the inclusion criteria would NOT be included in the internist's report. They would be included in the entity report that includes the endocrinologist. The Number of Quality Opportunities in this section contains, in the total column, all patients who had an episode attributed to the report entity who met the requirements for inclusion in the quality measure denominator. The actual rate is the rate for the report entity, and the peer rate is the rate for the entire peer group. The quality index is the actual rate divided by the peer rate. The quality index total represents the index only for the rules displayed in the Quality Measures section of the report. It will typically be different than the Overall Quality Index in the Specialty Patterns of Care Section, which represents performance across all of the EBMs included in the peer group definition. Indices on individual quality measures should only be considered meaningful if there are sufficient numbers in the total opportunities column.

Cost and Use

The 3 subsections of this report contain cost and utilization information for the report entity. Every claim that is part of an episode attributed to the report entity or the peer group is allocated into one of the seven service categories, based on CPT/Revenue code, place of service, rendering provider and ordering provider. This section of the report provides a ratio of the standard pricing results for the report entity relative to the exact same mix of episodes, compared at the severity level, for the peer group. This, combined with the next section of the report, helps to illuminate specific drivers of cost variation from the peer group. Examples of services that are included in the different categories are:

Hospital Services: All inpatient facility services; Outpatient facility services, including surgery, diagnostic (other than imaging and lab), and facility-based PT/OT; DME/MedSurg supplies

Radiology: Facility and professional components of radiology services, excluding therapeutic radiology. Selected diagnostic x-rays performed or ordered by a primary care provider are also excluded (these are assigned to Primary Care Core per below)

Laboratory: Facility and professional components of laboratory and pathology services, excluding selected lab tests performed or ordered by a primary care provider and typically performed in a PCP/physician office

ER: Professional and facility components of ER services

Primary Care Core: Evaluation and management services rendered by a primary care provider (office visits, nursing home visits, preventive care – does not include inpatient visits, ER visits or consultations); CXR, abdominal XR, and sinus XR; Minor lab procedures; Minor procedures and diagnostic tests, including diagnostic endoscopy, EKG and pulmonary function tests

Specialty Care: Evaluation and management services rendered by a physician other than a primary care provider; Diagnostic testing (other than lab and radiology); Allergy tests; Physical medicine and rehab; Professional component of surgery and anesthesia; Chemotherapy

Pharmacy: All pharmacy claims

The summary and measures subsection provides the cost and encounter detail that drove the service category indices in the previous subsection. Again, the values labeled actual represent the performance of the report entity. See portion of Episode Cost and Detail labeled "Using the cost and encounters ratios."The Actual Total Cost column provides the ability to get a sense of the relative importance of a particular service category variation to the overall cost variation for the report entity. For example, a total cost for a service category of $50,000 with a cost index of 2.0 represents $25,000 of cost variation (1.0 for the peer group would be $25,000), while a total cost for a different service category of $500,000 with a cost index of 1.25 represents $100,000 of cost variation (1.0 for the peer group would be $400,000). Note that that Overall Cost Index in this section is the same as in the Specialty Patterns of Care overview and is different, in most cases, from the Cost/Episode Index. That is because the Overall Cost Index is compiled from service category indices that are weighted depending on the peer group specialty. For example, the Primary Care Core category is weighted higher for an internist than for a general surgeon, while the Hospital category is weighted higher for a general surgeon than for an internist.

Utilization Rates Per 1,000 Episodes
This utilization rates subsection provides additional detail for helping to hone in on report entity cost variation. Some of these rates tie directly to the service categories in the Cost Index Summary above. The rates reflect results for the report entity (actual) relative to the exact same mix of episodes, compared at the severity level, for the peer group. Note that the results are reported as rates per 1,000 episodes as opposed to per 1,000 patients. The exception to this is the generic prescribing rate, which is defined as number of generic prescriptions divided by the number of prescriptions for which a generic rate is available for the episodes attributed to the report entity. Prescriptions for which a generic is not available are not included in the denominator. This can result in different rates than those seen in other generic calculation rates performed across all prescriptions. The index is calculated by dividing the actual rate by the peer rate. A higher index for generic prescribing rate would generally be considered better performance, while lesser utilization indices for the other metrics would typically be considered better performance. Note that the three inpatient measures may not be consistent with the Hospital service category above, as inpatient services are only one component of that category and typically represent less than half of the costs for the category.

Episode Detail

This section contains information similar to that in the Cost and Utilization Summary Measures section, except at a level of detail of the episode family. These are specific to the peer group, reflecting the most common episode families for that peer group, and there can be up to eight episode families displayed in a report. The Total Specialty Episode Costs represent the standard pricing costs for all of the episodes in that episode family attributed to the report entity. The comparisons are exactly the same as in the Cost and Utilization Summary and can be used similarly to determine the significant drivers of any cost variation and whether that variation is being driven by units or mix of services.

Using the cost and encounters ratios:

The encounters category can encompass a wide variety of unit types, ranging from E&M visits to units of chemotherapy administered. While caution should be exercised in some categories due to unit type variety, comparing the cost index in a service category with the relative ratio of the encounters can help illuminate whether units of service or mix of services is driving variation. For example, if the cost index is 1.5 in pharmacy where the actual encounters are 1,500 and the peer encounters are 1,000, it is likely that the cost variation of 50% (1.5 represents 50% more than the 1.0 of peers) is being driven by units (in this case prescriptions, most likely), rather than mix of services (more expensive medications). The ratio of actual encounters to peer encounters is 1.5 (1500/1000), exactly the same as the cost ratio. If in this case the actual encounters were 1,000, and the peer group encounters, 1,500, the encounter ratio would be 0.67 (1000/1500), making it very likely that mix of services was driving the cost variation of 50%.

Again note that comparisons at the episode family level should only be considered meaningful if there are sufficient numbers of episodes (a minimum of 30 has been suggested by some authorities).

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

Senate Committee on Rural Issues, BioFuels, and Information Technology

Testimony of Karen E. Timberlake, Secretary

Department of Health Services

WIRED for Health Act

March 3, 2010

Thank you Chairman Kreitlow and members of the committee for the opportunity to testify here today in favor of the WIRED for Health Act.

Wisconsin Is a Leader in Health Information Technology

In 2005, Governor Jim Doyle created the eHealth Care Quality and Patient Safety Board with the goal of improving the health status of the people of Wisconsin, as well as enhancing the efficiency of the state's health care industry through the implementation of electronic medical records systems in hospitals and clinics across the state and the exchange of the valuable information contained in those records.

In December 2006, that Board issued an Action Plan to the Governor which outlined the major steps Wisconsin would need to take in order to realize the full potential of health information technology:

- Establish a statewide health information technology platform;
- Increase provider adoption of health information technology, and create regional and statewide vehicles for exchanging data; and
- Link health care technology and data gathering with disease prevention and care management efforts.

What does this all mean for Wisconsin, and how will the WIRED for Health Act help?

Today in Wisconsin, approximately 60% of physician offices are already using some form of an electronic medical record. Another 19% are in the process of implementing such a system. That means that soon, 79% of physicians' offices and hospitals will be equipped with electronic medical records, compared to a national average of just 38%.

Wisconsin is also home to some of the leading health information technology providers – companies like Epic Systems, GE Healthcare, and the Marshfield Clinic – who serve clients across the state and across the country, and who stand to see their business opportunities expand

considerably not just in Wisconsin but nationwide thanks to the American Recovery and Reinvestment Act investments in health information technology, discussed below.

Many patients in Wisconsin now benefit from having comprehensive health histories and treatment records at their doctors' fingertips. In some parts of the state, electronic health information or even full medical records are exchanged locally, often within an integrated delivery system or between two health systems that treat many of the same patients. Wisconsin has also seen groundbreaking work in the area of using electronic health information for emergency department utilization management, for local disease surveillance, and for reporting on the quality of care provided to Wisconsin health care consumers.

What we do not yet have in Wisconsin, or in any other state, is the ability for clinicians to access the full spectrum of medical record information, including test results, medication histories, and other critical information, from any other medical clinic or hospital that a patient may have visited, on demand, in real time, at the point of care. Similarly, we still have roughly 20% of physicians in Wisconsin who are not yet using electronic medical records. Establishing the infrastructure to support further adoption of electronic medical records and to make the information they contain more available to doctors and clinicians locally, and across the state, is what the WIRED for Health Act is about.

The American Recovery and Reinvestment Act Has Made a Major EHealth Investment

President Barack Obama and the federal government have recognized the importance of investing in health information technology and health information exchange by including the following provisions in the American Recovery and Reinvestment Act of 2009 (ARRA):

(a) $386 million to plan and develop the infrastructure for statewide health information exchanges;

(b) $46.8 billion to provide incentives to encourage the meaningful use of electronic health records; and

(c) $375 million to create regional extension centers to help providers successfully implement and use health information technology.

Wisconsin has been awarded $9.4 million in ARRA funds for the planning and development of statewide health information exchange capability. An additional $9.1 million has also been granted to the Wisconsin Health Information Technology Extension Center whose purpose is to support physicians practicing independently or in small group settings in adopting and implementing electronic medical records. Beginning in 2011, an estimated at $500 to $800 million in federal funds is available specifically for Wisconsin health care providers through Medicare and Medicaid incentive payments to assist them in establishing and using electronic medical records systems.

The WIRED For Health Act Will Further Advance Health Information Technology in Wisconsin

The WIRED for Health Act creates a statewide, public-private corporation to support the adoption and use of health information technology, including statewide health information exchange.

The WIRED for Health Act will strengthen the ability of health care providers to share electronic patient data with each other and other authorized entities, such as public health, while protecting patient confidentiality, privacy, and security of the information. The Act will ensure that the following key responsibilities are carried out, ensuring that Wisconsin realizes the full benefit of electronic health information exchange while protecting patient privacy and the security of the information:

1. Building substantial health information exchange capacity statewide to support all of the following:
    a. Health care providers' meaningful use of electronic health records.
    b. Population health improvement.
    c. Reporting of health care performance.
2. Developing policies and recommending legislation that advance efficient statewide and interstate health information exchange and that protect consumer privacy.
3. Developing or facilitating the creation of a statewide technical infrastructure that supports statewide health information exchange and enables interoperability among users of health information.
4. Adopting standards for health information exchange in accordance with national standards, implementation protocols, and reporting requirements.
5. Managing and sustaining funding necessary to develop and sustain statewide health information infrastructure and services.
6. Monitoring health information technology and health information exchange efforts nationally and facilitating alignment of statewide, interstate, and national health information exchange strategies.
7. Developing programs and initiatives to promote and advance health information exchange to improve the safety, quality, and efficiency of health care and to reduce waste due to redundancy and administrative costs.

Enhancing the ability of our health care providers and public health professionals to exchange electronic health information will improve the overall health status of our citizens and realize economic benefits for our state by reducing health care costs. In addition, authorizing the creation of this corporation is an essential step in bringing additional federal dollars to Wisconsin to support our leading private sector health care providers and health information technology vendors and create jobs.

This past summer, I met with providers and stakeholders across the state in a series of meetings to obtain their input regarding the best ways to support health information exchange in Wisconsin. The messages were clear:

- Health care is a local business. More robust exchange of electronic health information locally is what matters most to health care providers.

- Begin at the beginning: Providers need basic, yet critical pieces of information like the ability to identify each unique patient and access medication histories and laboratory test results.

- Don't disrupt what is working today. Statewide health information exchange is important, but it should complement, not replace, the local efforts that have already been made.

- Statewide health information exchange should be governed by a public-private partnership that represents the full spectrum of Wisconsin's health care providers and consumers.

The WIRED for Health Act will establish the public-private partnership that our health care community has asked for to support further development of electronic health information exchange across the state. The establishment of this corporation is essential to carry out the planning and design required under the terms of our $9.4 million grant from the federal government.

Better Use of HIT Will Reduce Health Care Costs and Improve Patient Safety

Improving our use of health information technology is an essential part of our efforts to achieve better value for the money spent on prevention and treatment services in our health care delivery system.

We're all aware of the economic pressures the state and nation are facing and how high health care costs complicate the problem.

Controlling health care costs is one of the keys to improving the business environment for both large and small employers and growing our state's economy.

Health care leaders agree that as much as 30% of all care that is delivered in America, and in Wisconsin, is redundant, unnecessary, or even harmful to patients. That translates to $300 billion per year in health care expense—paid by consumers, employers, and state and federal taxpayers—that adds no value to patients. And if we apply national figures to our health care expenditures, we project that Wisconsin spends about $6 billion annually on unneeded, and in some cases dangerous, treatment of patients.

The United States Department of Health and Human Services estimates that reducing duplicative care, lowering health care administrative costs, and avoiding costly and sometimes fatal medical errors through better use of health information technology will result in an annual savings of $140 billion, or close to 10% of total health care spending in the United States.

The WIRED for Health Act will create the framework for a technology platform that will allow health care providers to begin to significantly reduce these costs.

Expanding our adoption and use of health information technology advances three critical goals:

1. Improving the overall health status of our citizens. Ensuring that clinicians have the most complete information about a patient's medical history, allergies, and prior tests and treatments will vastly improve the quality and safety of health care in Wisconsin.

2. Reducing redundant tests will drive down health care costs, making it easier for employers to offer health insurance, and making Wisconsin more competitive as a place to keep or relocate a business.

3. Maximizing the incentive payments available to private health care providers under ARRA. This federal funding will add fuel to Wisconsin's high-tech economy and create more family-sustaining jobs for Wisconsin workers.

This legislation will benefit patients in hospitals and clinics across the nation while bringing millions of dollars to our state's economy. It allows Wisconsin to capitalize on an opportunity to improve health care while bringing valuable economic resources to the state. Thank you.

March 3, 2010

TO: Members of the Legislature

FROM: Wisconsin Collaborative for Healthcare Quality
Wisconsin Health Information Exchange
Wisconsin Health Information Technology Extension Center
Wisconsin Health Information Organization
Wisconsin Primary Healthcare Association
Wisconsin Medical Society
Marshfield Clinic
MetaStar
Rural Wisconsin Health Cooperative
Department of Health Services
Wisconsin Hospital Association

Re: Support for the Wired for Health Act -- Assembly Bill 779 and Senate Bill 579

We, the organizations listed above, represent health professionals and information technology vendors dedicated to improving healthcare quality and efficiency through the broad based, secure use of electronic health records. We urge you to support Assembly Bill 779 and Senate Bill 579, the companion bills referred to as *The Wired for Health Act*.

- The Wired for Health Act will strengthen the ability of health care providers to share electronic patient data with each other and other authorized entities, such as public health, while protecting patient confidentiality, privacy, and security of the information.

- The federal Recovery Act includes funding to (a) plan and develop the infrastructure for statewide health information exchange (HIE); (b) provide incentives to encourage the meaningful use of electronic health records (EHRs); and (c) create regional extension centers to help providers successfully implement and meaningfully use EHR technology.

- Wisconsin is receiving $9.4 million in federal Recovery Act funding for the planning and development of statewide HIE and $9.1 million to form a regional extension center.

- Wisconsin must create a state-designated entity (SDE) to govern and coordinate the implementation of statewide HIE to carry out the terms of its funding under the Recovery Act.

- The development of statewide HIE will assist private health care providers in Wisconsin in obtaining federal incentive payments under the Recovery Act – estimated at $500 to $800 million -- for establishing and using EHR systems. The use of EHRs can reduce medical errors, unnecessary duplicative tests, and costs to consumers.

- Federal funding for HIE and EHRs will also help Wisconsin-based information technology vendors create more, family-sustaining, high-tech jobs for Wisconsin workers. Their work will be used to benefit patients in hospitals and clinics across the nation while bringing millions of dollars to our state's economy.

The Wired for Health Act:

- Helps Wisconsin capitalize on an opportunity to improve health care while bringing valuable economic resources to the State.

- Creates a state-level, private-public structure in the form of the state-designated entity (SDE), to govern and coordinate the implementation of statewide HIE. The SDE is not a regulatory agency -- it may not impose mandates and must work in concert with existing health care providers to promote the meaningful use of EHRs to improve health care quality and efficiency in the state.

We hope you will support AB 779 and SB 579 -- the Wired for Health Act. Thank you for your consideration.

WISCONSIN HOSPITAL ASSOCIATION, INC.

March 3, 2010

To: **Members of the Senate Committee on Rural Issues, Biofuels, and Information Technology**

From: **Steve Brenton, President**

Re: **Support for Senate Bill 579**

The Wisconsin Hospital Association (WHA) strongly believes that implementation of a statewide health information exchange (HIE) system can result in better health care quality, safety and value. We are pleased to support SB 579 as a first step toward that goal.

Under the terms of a $9.4 million federal grant, the state must select a state-designated entity (SDE) to coordinate the planning and implementation of a statewide HIE system. SB 579 will enable a private-public structure in the form of an SDE to carry out this function.

Hospitals in Wisconsin have invested tens of millions of dollars in recent years to advance their health information technology capabilities to provide safer, more cost-efficient and higher quality care to their patients. In the Milwaukee area, the Milwaukee Health Care Partnership, led by the five Milwaukee hospital systems, has implemented an HIE system focused thus far on emergency-department care for vulnerable populations. Under the ED Care Coordination initiative, clinicians providing care in Milwaukee emergency rooms have access to information about care that may have been delivered at another location, alerting them to possible prescription-drug interactions, recent diagnostic tests, and other information that improves the quality and cost-efficiency of care. Experience with this project to date shows the promise of broader HIE applications.

Although the results in Milwaukee have been positive thus far, HIE in Wisconsin is still in its infancy, in large part because of the technical complexity of HIE systems and processes. Efforts to evolve HIE in Wisconsin must be coordinated with input from the stakeholders who have the technical and clinical knowledge to make it work.

The proposed criteria for an SDE in SB 579 provide an appropriately balanced structure to plan and implement a statewide health information exchange. Although states have the option of creating a completely public structure to oversee the development of HIE capabilities, **we are pleased that this bill provides for formal representation from the private sector.** At the same time, the bill recognizes that there are likely to be key questions of public policy that are outside the scope of the responsibilities of the SDE, which has no regulatory authority. We expect that as part of its planning and implementation activities, the SDE will identify statutory or regulatory issues and make recommendations for future legislative action that will facilitate the evolution of Wisconsin's HIE system.

In the coming months, we look forward to working with the Department of Health Services, the Legislature, the future SDE, and the wide array of stakeholders interested in implementing a statewide health information exchange. This bill is one step in that process, and we are pleased to support SB 579.